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FOR THE PHYSICIAN IN GENERAL PRACTICE



SCHWARTZ

FALL, 1954

SURGERY-SEEKER—Page 74

THE
PSYCHIATRIC
BULLETIN

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THE COVER

The surgical addict — the patient who has a desire for multiple or unnecessary operations — may be difficult to recognize or understand. Like the lizard on the cover, the addict will frequently relinquish a part of himself in the presence of an unconscious feeling of fear or danger. His motives, both conscious and unconscious, have been described by psychiatrists; however, it is enough for the physician to know that in many instances such a patient is seeking an answer to some psychological need. Keeping this in mind, the physician may be able to prevent the surgery-seeker from damaging himself physically.

The drawing on the cover is by Mr. Joseph F. Schwarting.

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SURGERY -

SOME PATIENTS FEEL THAT when bigger and better surgical procedures are devised, *they* must undergo them. That surgical addiction exists is well known to medical men. However, the task of recognizing and allaying this proclivity in the individual patient before multiple unnecessary operations ensue is quite a different matter.

The medical profession as a whole deplors unnecessary surgery. The American College of Surgeons has gone on record to condemn it. And physicians representing all the various specialties unite in impugning that small percentage of surgeons who may occasionally be overly quick to use their scalpels.

Unfortunately, the medical profession has less control over the patients who go in search of superfluous surgery. The physician has no way of knowing how many other physicians have been previously consulted; how many times the recital of symptoms has been rehearsed and embellished before a convincing case

can be made out in favor of some operation the patient may desire.

That the profession regards surgical addiction as serious is attested to by extensive statistical surveys which reveal that numerous operations have been performed which proved to be neither required nor relief-giving. The majority of these surgical procedures were prescribed in the best of faith. But it would be difficult indeed to ascertain to what extent the patient's wish for surgery may have influenced the physician's ultimate decision to operate on him.

The statistics are appalling

Miller made a now-famous survey of gynecological operations performed in several clinics. His findings indicated that some 78 per cent of the ovaries and 30 per cent of the uteri removed contained no pathological lesions whatsoever.

Macy and Allen followed 235 patients for six years, during which time 200 of them underwent 289 operations despite the fact that they

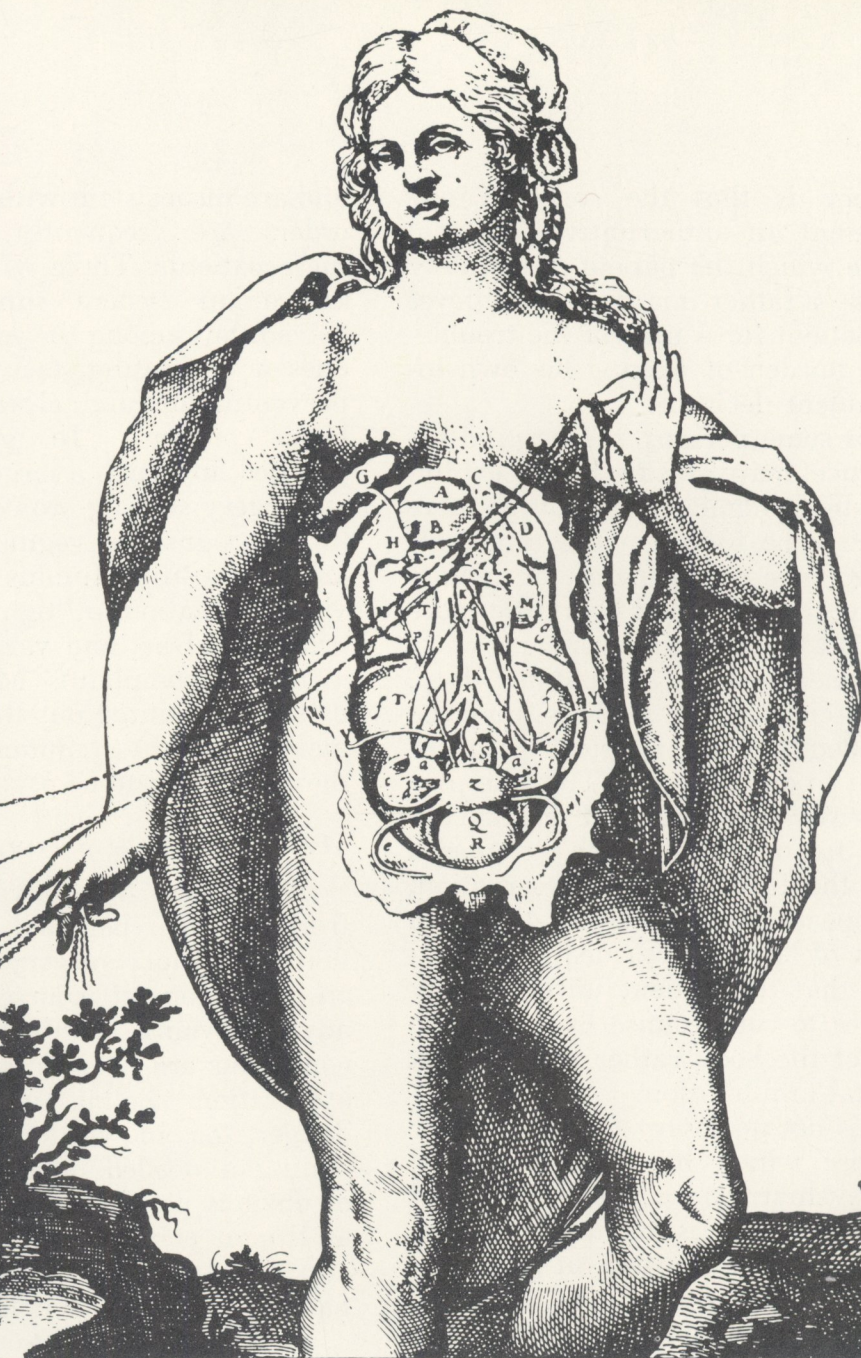
revealed no evidence of organic disorder. Of these 200 patients, 156 were women and over half of them were operated on for pelvic distress. Following surgery, not one of these showed any appreciable relief of symptoms.

Browne, McHardy and Welco studied 250 patients with gastrointestinal complaints but with no convincing evidence of organic disorder. They found that 51 per cent had undergone operations which failed to relieve their symptoms.

McGeorge investigated 132 females hospitalized for nervous and mental disorders and found that 16 per cent had undergone ill-advised surgery, for psychogenic complaints.

Ulett and Gildea compared 214 chronically psychoneurotic women with 100 women selected as controls who were psychologically well adjusted. They found that 60 per cent of the psychoneurotic group had been subjected to major surgical procedures, 43 per cent of which involved gynecological procedures. Of

SEEKER



the control group, only 32 per cent had undergone major surgery and only 15 per cent of these operations were pelvic.

A survey by Bennett disclosed that 150 psychoneurotic patients underwent 244 operations before their illness was recognized as psychogenic. The impact of this survey is further strengthened by the fact that the surgical procedures employed were not curative, but when their illness was finally diagnosed as psychiatric and psychotherapy was provided, 80 of these patients were fully recovered. Commenting on the documented evidence of the Bennett survey, Dr. Karl Menninger pointed out that "many of these patients demanded the type of treatment they received," prior to the psychiatric diagnosis and institution of psychotherapeutic measures.

Various psychological motivations are suggested

Psychiatrists have long conjectured on the motivations which

prompt the patient's quest for surgery. A classic treatise prepared by Dr. Karl Menninger two decades ago is still extensively quoted in recent literature dealing with the problem of surgical addiction. This delves into the possible psychological mechanisms underlying the patient's desire for surgery and attempts to show why any procedure as painful and incapacitating as an operation could appear desirable from the patient's viewpoint.

Perhaps the motive most easily understood is that of secondary gain. Many disagreeable alternatives may be temporarily averted through "surgical default." In many cases, this can hardly be described as an unconscious mechanism, for the patient may knowingly solicit surgery as a solution for some insurmountable emotional problem. The patient may feel, somehow, that by being sick and helpless for a while, he may regain the waning attentions of a recalcitrant spouse, or postpone for an indefinite period some dreaded

event, such as marriage, divorce, or entry into the armed forces. In a situation such as this, the operation becomes a "lesser of two evils" solution and a temporary stopgap in which valuable time is gained to pursue a new course. In addition, the patient acquires a sympathy-provoking condition which (he hopes) may be just what is needed to alter the unfavorable turn of events. Thus, when a patient attempts to exert pressure in favor of a surgical procedure, it may be quite illuminating for the physician to study rather closely the patient's emotional status and immediate life situation.

More insidious, however, and certainly more difficult to recognize, are those factors which are totally unconscious and which answer a deeper, less rational need of the patient. Psychiatrists claim that often the very appearance of symptoms for which surgery would be indicated is dictated by the patient's unconscious. Among the deeper unconscious motivations for an addiction to

surgery is that the surgeon may represent an authoritative, paternal figure which the patient desperately needs—a father-image which relieves the patient for a time of the troublesome burden of making his own independent decisions.

For some persons, the hospital experience may gratify latent exhibitionistic tendencies, but this is more likely to be found in the timid, retiring type of person for whom bodily display would be a little more difficult than for the average.

A means of atonement for deep, unconscious guilt feelings may be provided by the physical pain incident to an operation. To those psychiatrists who accept Freud's concept that a "death wish" competes with the force for self-preservation, it appears reasonable to think in terms of "partial suicide." This suggests that the patient unconsciously decides to compromise by giving up part of the body rather than submit to total annihilation.

It is not necessary to accept every premise which has been advanced by psychiatrists in their studies of polysurgery. It is sufficient for the physician to know that in many instances repeated attempts to obtain surgery are in answer to some psychological need. If he keeps this in mind, the physician will be less gullible and less pliable in the hands of the patient who seeks unnecessary operations.

Possible "signs" of the surgical addict

Whenever it appears that a patient is trying unduly to influence the therapeutic course in favor of a surgical procedure, the physician should be alert to the possibility of some psychic motivation. If the patient reports that some other physician or physicians have refused to operate on him, it will be well to discover why. A most convincing sign of the tendency to surgical addiction is a body bearing multiple operative scars. Also, "symptoms" which bespeak psychosomatic illness

and are inconsistent with organic disorders are frequently offered by these patients. These will vary with the organ system supposedly involved, but among the more familiar ones are sweating, tachycardia, hyperventilation and elevated systolic blood pressure. In gynecological practice, in which a large percentage of surgery-seeking women are seen, further signs are vaginospasms and an oversensitive fundus during pelvic examination, a "tight" abdomen, pruritis vulvae, and various illogical menstrual complaints. Many authorities have pointed out that the more inexplicable the symptoms, the more they are likely to be psychogenic.

Avoidance of the polysurgical pitfall

Whenever the physician feels, from his own personal observation, that exploratory surgery is indicated, an operation of course should be advised. Many obscure pathological conditions are detected only through exploration. Bellak warns of the danger, too, in withholding or postponing a needed operation because of obvious psychic disturbance. But, as Elman points out, it is never the aim of surgery to remove "normal parts of abnormal people."

The psychiatrically-oriented physician is ever alert to the correlation between physical and psychic illness. No psychogenic disorder can be diagnosed unless the physician first suspects that it exists. And in order to recognize the psychosomatic component of any illness, the patient's emotional and situational stresses must be evaluated. Further, the physician should endeavor to determine whether the symptoms are psychological, in accordance with known organ function.

Dr. Walter L. Thomas has suggested several useful measures by which this may be accomplished.

First of all, he warns, do not be in too great a hurry. Be patient and invest a little time in obtaining the patient's story. Although what the patient is saying may not seem immediately relevant, there is nothing irrelevant when one considers why the patient needs to say it. Let the patient talk freely, and draw him out by occasionally repeating a phrase after him. When the voice changes tone, or the patient becomes positive and insistent in his means

of expression, an emotionally-charged situation may be suspected. Closer questioning then may uncover some troublesome emotional state which is closely allied with the symptoms. There are several leads the physician may employ in questioning the patient. For example, the question "what did you do then?" elicited this response: "Well, finally the pain got so bad, I had to call my husband back from his mother's house." Jealousy, frustration and rage are productive of very real pain, and frequently the patient cannot distinguish the mental component in physical pain. Nor can the physician if he does not take the time to find out about it.

In selecting a physician to consult, the patient invariably seeks out an individual he holds in the highest regard. The patient looks to his physician to provide the emotional support he needs. This is not accomplished automatically, or without a warm, personal interest in the total fabric of the patient's troubles. Since so large a part of human suffering is mental, it is not enough to take at face value whatever the patient says outright, to rely on physical signs and laboratory findings alone, to concentrate on the diseased part, rather than the disordered individual. The best interests of the patient are served by studying the whole patient and getting the whole story, and only then deciding whether or not he really needs the proposed surgical procedure.

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JUNG



AT BURGHOLZLI, SWITZERLAND in the early part of this century, a distinguished group of psychiatrists were enthusiastically learning about the subject of psychoanalysis. The Director of the Psychiatric Clinic at Zurich at that time was Eugen Bleuler, and in this group was Carl Gustav Jung, who was senior staff physician, chairman of the psychoanalytic circle, and an ardent supporter of the theories of Sigmund Freud. Jung had studied medicine at the University of Basel and had spent one semester at the Salpêtrière in Paris. While there, he had studied under the tutelage of Pierre Janet, as Freud had studied under Charcot, a generation before him.

Jung published many papers while at Burgholzli, and one of them, written with Riklin in 1904, described a new word association test which made him famous. It also marked the beginning of a new phase of psychological study, that of interpretative psychiatry. It is of interest to note that at this time Jung had still to meet Freud in person. That meeting did not take place until 1907.

The years of Freud's and Jung's association were productive ones, with additional researches into psychoanalysis. The break between

them did not come until 1913, although before that time their increasing divergence of opinions had become apparent. In 1912 Jung published *The Psychology of the Unconscious*, in which were some criticisms of Freud's theories. In 1913 Jung left his own school of psychoanalysis and, after that, referred to his conceptions as analytical psychology and complex psychology.

There was more than one basis for Jung's intellectual departure from the Viennese school. Besides personal reasons there were major developments in his and Freud's theories that were not compatible.

Jung made two major contributions to his subject. One was his classification of personality, the other the theory of the *collective unconscious*. The latter was an amplification of Freud's idea of the "archaic traits"—racial or historic concepts, atavistic experiences, psychological symbols. Jung's idea was that of individual inheritance of all psychological experience. He saw the parts of the personality as the ego, the unconscious, the personal unconscious, and a *collective unconscious*. Within the personal unconscious came the drives and emotions more primitive than those that are readily discernible, yet capable of rational control by the will when

they did rise to the surface of consciousness. The *collective unconscious* contained the deepest forces, instinctual and emotional, that could never come to the surface and could never be controlled. Repressed material and memory came within the personal unconscious. At the deeper level occurred the archetypes—images found in all mythology, folklore, and religions, unshared experiences not consciously integrated into the mind, disturbing elements affecting the individual regardless of extrinsic influence. This group of symbols and drives was, according to Jung, manifest in visions, dreams, hallucinations, and in some of the creative processes.

Jung's other major contribution was his classification of personality types, a typology based only on psychological aspects. He did not try to attribute the differences to particular causes with predictable results, although he did consider the possibility of constitutional bases. The first of the papers on this work was published in 1920. The original distinction was that of extrovert and introvert. These terms mean that the individual's fundamental energy is projected outward toward the world or away from it to his inner self. Jung subsequently found this grouping to be superficial, because

Please turn to page 92



PSYCHIATRIC DISORDERS ASSOCIATED WITH **parkinsonism**

ALTHOUGH PARKINSONISM is regarded as a neurological disease, emotional tension is known to increase the tremor. The course of the disease may also be exaggerated by trauma, severe infection and emotional upset. Schwab, Fabing and Prichard, in an excellent review of this question, reported a study of some two hundred patients. They found that the psychiatric syndromes fell into four different groups: (1) psychiatric disorders unrelated to the paralysis; (2) mental disturbances reactive to the disease; (3) psychiatric symptoms produced by medication for the paralysis; and (4) paroxysmal psychiatric disorders probably related to Parkinsonism.

Group 1: Unrelated psychiatric disorders. These disorders may fall into either the category of the neuroses or the psychoses; but in patients with Parkinsonism showing psychiatric symptoms an adequate history is important to determine the

presence of previous episodes in the life of the patient. Naturally, in patients with Parkinsonism who are prone to develop these reactions, the additional stress of chronic illness may precipitate them again. Other than that there is no etiologic relationship.

Group 2: Reactive mental disturbances. In this group of patients the psychiatric symptoms result from the emotional stress produced by chronic illness. This is apparently the habitual pattern of reaction to stress. When their lives are going smoothly, they adjust adequately; but should they become ill, they may develop a variety of psychiatric complaints—depression, excessive worry, preoccupation with the symptoms, many somatic complaints, sleep irregularity, and irritability.

Group 3: Psychiatric disturbances caused by medication are particularly apt to occur in elderly patients, and use of some of the older drugs may produce acute confusional

states. These are similar to other toxic reactions, and the physician should be on the alert for alterations in time and space orientation, delusional ideas, as well as somatic symptoms. If the symptoms are caused by the drug, they will clear up within 48 hours after the drugs are withdrawn. Even the newer drugs may produce similar states at times.

Group 4: The paroxysmal disorders probably related to Parkinsonism. These disorders are characterized by their paroxysmal nature, their unusual symptomatology and their association with oculogyric crises. Oculogyric crises may last from a few minutes to an hour and usually consist of a first upward deviation of the eyes and retraction of the head. In some instances the eyes may be turned to the right or to the left and rarely are fixed in a forward stare. It is interesting that the subjective discomfort is usually much greater on the side in which the Parkinson's disease is most severe. In general these attacks are apt to occur late in the day when the patient is suffering from fatigue or is emotionally distressed. There may be two or three attacks per day, or one every few weeks at regular or irregular intervals. During the attacks the patient is helpless, suffers pain, and has feelings of terrific anxiety. Most attacks end in sleep from which the patient awakens feeling refreshed; at other times the attacks cease spontaneously. Often general restlessness, dizziness, flushing of the face, and diplopia occur with the attacks.

Anxiety is one of the important symptoms associated with these crises. These patients do not reveal a past history of anxiety attacks; furthermore, the attacks usually disappear when the Parkinsonism is under effective medical control. The anxiety in these attacks is much greater than that in neurotic anxiety. Patients experiencing these anxiety attacks with their Parkinsonism often have the feeling of impending death and abject terror. Schwab, Fabing and Prichard record a typical case history: a 47-year-old woman developed stiffness and soreness in the right arm and leg with little evidence of tremor. Her psychiatric history revealed that in the past she

was an ambitious, over-conscientious, serious individual who prided herself in perfection. There was no history of any mental disorder, and with the exception of a bout of severe influenza in 1918, she enjoyed sound health until the onset of her Parkinson's disease. She had oculogyric crises for two years, during which her eyes rolled upward and tended to pull to the right. These attacks lasted 20 to 30 minutes. In the last six months they were associated with feelings of intense anxiety and terror which the patient was unable to describe. The onset of these feelings was sudden, and she felt impending doom, was conscious of her heart beating fast and also of the movement of her eyes. Her feeling during these attacks was of imminent disaster, and that none occurred was always a surprise to her. There was an increase in the frequency of attacks during a period of being overburdened socially, and some improvement following a change in her medication.

Obsessive thinking or compulsive counting is another phenomenon seen accompanying oculogyric crises. This may occur in people who showed no such personality traits prior to their neurological disease, or if such traits were present they were very mild in degree. Most patients in this group complain that the more they attempted to dismiss the repetitious phrase or digits, the more severe the obsessive thinking became. Some anxiety may also accompany this type of disturbance.

Paroxysmal depression of profound proportion may be associated with oculogyric crises. Fortunately, it is usually of short duration. It is not unusual for persons to feel in such helpless gloom that death seems not only inevitable but even welcome. Suicides have occurred during these periods.

Paranoid ideas with great hostility toward the environment have been observed during these seizures. In some of the patients the hostility is limited to the side associated with the disease so that, for example, if the neurological symptoms were primarily on the left side everything to the left of the patient might seem hostile and unfriendly while that on the right seemed normal.

Another associated symptom of

these crises is peculiar feelings in the limbs. These may be burning in the skin, particularly at the back of the neck and top of the head; feelings of tightness, pressure and pain that may be dull or sharp, knife-like or burning. At times there may be the feeling that deep within some one of the limbs is some sort of foreign body; these attacks very frequently last the whole day but at times may be shorter. Some of the complaints of pain and heat voiced by these patients are quite similar to those reported in known lesions of the thalamus.

Schizoid reactions are occasionally reported, as are states of great agitation and tension.

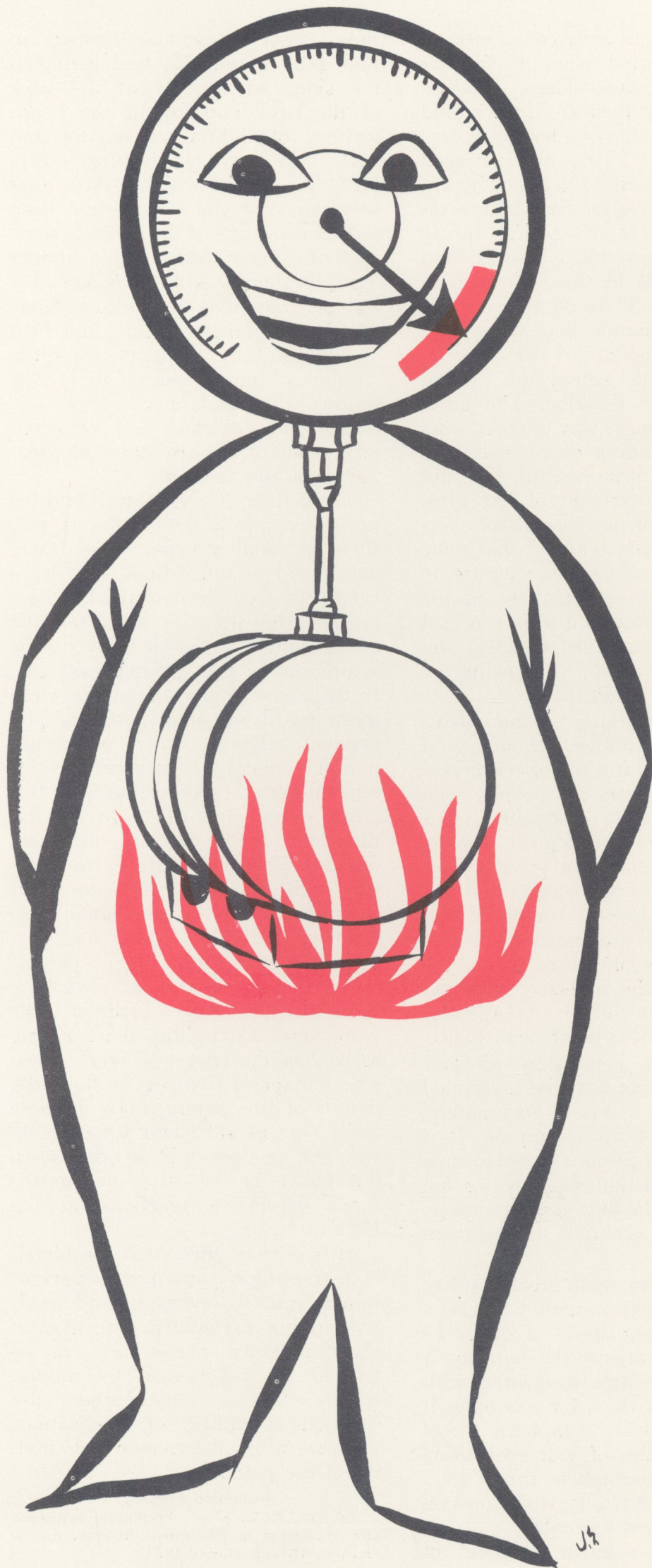
From their study Schwab and his associates group their patients into three personality types. They found one group of individuals who were relatively free from conflict, whose attitude toward life was realistic or perhaps phlegmatic. Psychiatric symptoms in this group were rare. In their next group the patients were more sensitive, submissive and dependent. These traits were not marked enough to warrant psychiatric diagnosis. About half of this group were inclined to psychiatric disorders with their neurological disease. The third group were patients with unusually high standards for themselves, who were ambitious, assertive individuals with no tolerance for frustration and disappointment. This group also included those individuals who were inclined to be suspicious, demanding, tense people as well as the ones who were obsessive and perfectionistic in their demands of life. Again, none of these traits was of sufficient intensity to warrant a psychiatric diagnosis, but many in the latter group suffered depressive reactions to the Parkinsonism.

It is obvious then, that the physician treating a patient with Parkinsonism must be aware of and sensitive to the psychiatric disorders in these patients. Some have to be treated by psychiatric techniques, while others are manipulated by judicious handling of medications used to control the tremor and rigidity of the patients.

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Psycho



HYPERTENSION is one of the most prevalent diseases among "civilized" people. The number of persons presenting the signs and symptoms of hypertension is appalling, and this number is increasing rather than decreasing. Despite the high incidence, and despite the physician's familiarity with the clinical picture, the etiology of hypertension remains a medical enigma.

The most confusing and yet the most characteristic feature of early "essential" hypertension is that the sphygmomanometer reading seems to be at cross points with organic findings in the patient. If close scrutiny is then made of the patient's life situation, some environmental pressures or emotional conflicts may be found which are incompatible with a normal and happy adjustment. Many investigators believe that psychogenic factors constitute the major contributing force during the initial stages of the disease. If this theory is valid, any form of therapy which fails to include some form of psychiatric treatment can hardly be expected to produce the most beneficial results.

Symptomatology may be misleading

There are a large number of symptoms associated with essential hypertension. Some patients present only one or two, while others will enumerate a long list of complaints. Headache is probably the most common complaint. Constipation may be given as a symptom. Quite often the patient will come equipped with a preconceived notion that constipation has led to auto-intoxication, which in turn is responsible for his headaches. This notion is jarred from the mind of such a patient only with difficulty. Perhaps this is understandable in the light of the fact that some medical men still cling to the idea of colonic irrigation as a health measure. Vertigo and nausea are also among the chief complaints of hypertensive patients.

therapy in Essential Hypertension

There is usually no justification for *the severity* of these symptoms, on the basis of *the degree* of hypertension. The physician will want to make sure that the presenting complaints are not isolated symptoms of some other disorder. If disorders other than hypertension are ruled out, the patient should be corrected in his assumption that his "blood pressure" is responsible for all his bodily discomforts, lest he develop a well-organized cardiac neurosis or hypertensive phobia.

After hypertension has persisted in the patient for some time, certain arteriolar changes occur. As the pathological process continues, the hypertension also progresses, yet all the while it appears that the symptoms are more severe than can be accounted for by organic factors. Indeed, in the process of essential hypertension, the symptoms at no time seem to correspond logically with the degree of organic change.

It has been demonstrated repeatedly that removal of emotionally troubling situations from the life of a hypertensive patient is often followed by an appreciable lowering of the blood pressure. In some instances, the overt expression of symptoms will have disappeared completely.

The so-called "hypertensive headache" is illustrative of this principle. It has been noted that the headaches often complained of by patients suffering from hypertension are not always correlated in degree or in time with the episodes of greatest hypertension. These headaches may subside following relief of emotional trauma, without any appreciable change in the blood pressure itself. However, this idea may be difficult for the patient to accept. It seems reasonable (perhaps too much so) to assume that hypertension would necessarily produce a headache. Thus the patient approaches his physician in the belief that his headache is caused by "bursting blood

vessels in the brain." Often, the physician will accept this premise, prescribe drugs in an effort to bring down the blood pressure or minimize the pain without even questioning the patient regarding his current life stresses. Of course, cerebrovascular accidents, or "little strokes" must necessarily be eliminated from this category, but when the clinical signs present no evidence of these, the symptoms can frequently be dispelled with an explanation of the relationship between life stresses and these physical symptoms.

Modes of therapy

The preferred therapy for "essential" hypertension remains a matter of some dispute, although diverse measures have been employed by investigators, clinicians, surgeons, dieticians and psychiatrists, in an attempt to stay the progressively crippling effects of the disease. Among the various therapeutic approaches to the problem, some stress dietary factors, others depend on medication, and still others rely on surgery to bring about a reduction in the blood pressure before irrevocable organic changes take place in the circulatory system.

To illustrate the different types of therapies which have been used for hypertension is to reveal the varying points of view among physicians regarding the etiology. A large number of hypertensive patients, for example, have been restricted to a rice diet, with little or no improvement in their symptoms. While dietary considerations emphasizing a reduction in salt intake may have some value in the treatment of hypertension, it has not been conclusively established to the satisfaction of all clinicians that diet is responsible or curative in the management of this syndrome.

Lumbodorsal sympathectomy has been used extensively by a number of surgeons in an attempt to preclude the effects of neurogenic factors.

This procedure has produced varying results and therefore cannot be regarded as unfailingly reliable.

Within recent years, the administration of hypotensive drugs for pharmaceutical ganglion blockade has begun to supersede surgery as a "less drastic" measure in the control of hypertension. However, it is debatable whether a drug potent enough to produce severe postural hypotension should be regarded as "less drastic" even than bilateral sympathectomy.

Strangely enough, even though all of these therapeutic measures have met with but limited success in controlling hypertension, the possible emotional and psychological factors are often overlooked. In all probability a number of different factors are involved, in a well-established case of hypertension. Indeed, nephrogenic, neurogenic, chemogenic and psychogenic factors may work together to elevate and maintain high blood pressure. Since early in the process it is frequently demonstrated that no organic difficulty is present, it would seem reasonable to direct the major therapeutic effort to psychological factors.

The psychogenic factor

Some investigators have proposed the suggestion that in the first stages of hypertension the only demonstrable symptoms are those found also in patients diagnosed as neurotic. From this suggestion an inference might be made that psychogenic factors are more important than others in the etiology of hypertension. However, in other types of neurotic patients the symptoms may crop out in other organs or systems of the body. It would seem that "pre-hypertensives" (those individuals who show an inordinate elevation of blood pressure under stress) may have inherited an innate proclivity for diffuse arteriolar spasm. If this is true, then it is plausible that any stressful situation would produce

elevated blood pressure and that if this situation persisted, organic damage would occur.

In a series of controlled tests made on such "prehypertensives" by one group of investigators, it was found that these patients responded to stress with a sharp elevation of blood pressure. A "normal" control group showed a corresponding rise in blood pressure under similar stressful situations, but the pressure fell to normal limits again shortly after the stimulus was removed. In the "prehypertensives," however, the blood pressure remained high for a long period following incitation and subsequent removal of the stressful stimuli. It is difficult to ascertain whether this continued elevation of blood pressure long after the removal of the stimulus was the result of exaggerated vasoconstrictive response to stress or to the neurotic patient's inability to resolve the emotional conflict as quickly as a more normal person would.

Many prominent investigators are convinced that emotional disturbance, particularly that resulting from suppressed hostility, is a major contributor to essential hypertension. One of the leading authorities in the field of psychosomatic medicine, Weiss, writes: "Emotional stress at times seems to precede the onset of hypertension, and anxiety bears a close relationship to the aggravation of existing symptoms in hypertension."

Hambling becomes even more specific by saying, "It is likely that emotions play a strong role in the blood pressure fluctuations of an individual hypertensive, and that a long-sustained situation charged with intense but unexpressed hostility may account for clinical deterioration."

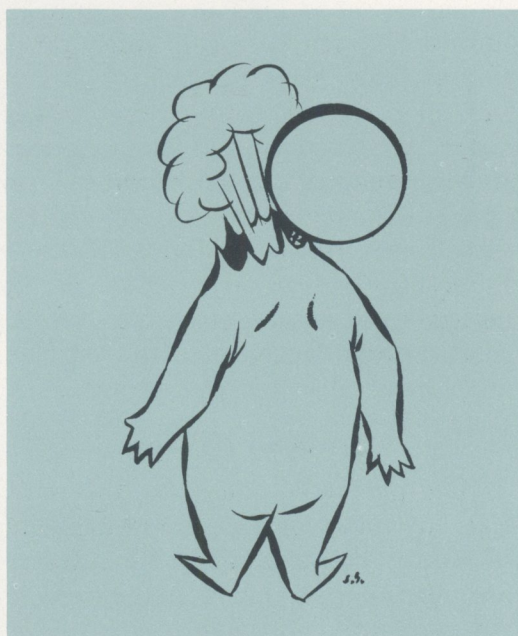
To those physicians who possess a well-defined psychosomatic orientation, subjecting the patient with early hypertensive manifestations to any therapy which fails to embrace psychological factors seems incompatible with the requirements and best interests of the patient.

Control of the psychogenic factor

In the vast majority of hypertensive patients, deep psychotherapy is neither required nor recommended. Often, deep psychoanalytic

probing, especially in older people who make up the largest number of hypertensives, may evoke even greater anxiety by crumbling the patient's habitual defenses. The end result in such a procedure can intensify the symptoms and result in further elevation of blood pressure.

Nevertheless the family physician can do much toward alleviating some of the anxiety carried by the hypertensive patient by employing



well-established superficial psychotherapeutic measures. These measures could include calm reassurance and manipulation of the patient's environment, either physical or emotional, to remove obvious stressful circumstances.

In some patients, mild sedation may be necessary to enable the patient to reduce his over-response to stress. Care must be taken, however, to choose a sedative which does not in itself have a hypertensive effect. A mixture of chloral hydrate and bromides has been found efficacious by some physicians, although careful attention must be paid to insure that the individual patient does not overdo his medication. It is to be remembered that the bromides leave a cumulative effect and can cause intoxication.

Alcohol in moderate quantities may prove helpful, both as a vasodilator and an aid in the relaxation of emotional tensions. Conversely, tobacco may prove harmful because of its vasoconstrictive properties, yet the physician will have to judge on the basis of each individual patient whether it would be more conducive to anxiety for the patient to be

forced to give up the pleasures of smoking. It is often difficult to know where to draw the line, but it has been suggested that a rise in blood pressure of 10 mm. Hg. after smoking a cigarette should be considered an indication to stop the use of tobacco.

Regular and frequent visits to the same physician can prove most reassuring to the hypertensive patient. During these visits, anything the physician can do to help the patient to understand the relationship between emotional upsets and hypertensive episodes should be most helpful, once the patient has himself recognized the feasibility of such a relationship. In many cases improved emotional adjustment is possible only following some environmental manipulation. Difficulties arising from sexual problems, family status, vocational problems or financial worries may require adjustment before the patient can be helped to overcome the tensions in his emotional life.

An interview, guided by the physician, often proves revealing to the investigator and to the patient as well. A fragment of conversation from a case history recorded by Shapiro and his associates illustrates this point. The patient, a 43-year-old machinist, reported that his first "symptoms" of hypertension appeared following union-management difficulties beginning in 1944. As president of his local union, the patient had been instrumental in forming the labor-management contract in effect at his factory. Shortly before the onset of his symptoms, this contract was broken by a split in the union. The following dialogue is an excerpt from the clinician's investigation:

"Q. Did you have anything to do with the original contract?

A. Yes, I was on the original committee... I had my heart and soul in it. It was almost an obsession.

Q. What do you mean by an obsession?

A. It was almost my very life. I had everything in it.

Q. Do you think that had anything to do with your medical trouble?

A. Well, not the turn of events in itself—no. I don't think so. I attribute the trouble more to overexertion and loss of sleep.

Q. You think it was the hard work you put in rather than the feeling that you expressed that you had your heart and soul in it?

A. That's right.

Q. You've done hard work before, haven't you? Did it cause any sickness?

A. No.

Q. Do you get mad easily?

A. No, it takes an awful lot. I suffer it in here inside (pointing to chest).

Q. How do you feel when you get angry or mad?

A. I keep it to myself. I choke up a little. I get nervous and jumpy."

Prior to this interview, the patient had no thought of a possible connection between emotional turmoil and

the onset of illness. When it was brought out that he had bottled up his rage inside him following the defeat of his union, it became possible for him to comprehend that emotional tension might conceivably be translated into hypertension. In the above case, the patient would have doubtless gone on attributing his symptoms to overwork indefinitely, had he not participated in several interviews with his therapist which revealed the strength and destructiveness of his emotional trauma.

In summation, it can safely be stated that effective management of the patient with essential hypertension requires treatment of the whole patient, rather than isolated attacks on various aspects of his "disease."

The physician who limits his treatment to physical measures alone proffers only a portion of the therapy readily available. In many cases, psychotherapy is the easiest therapy of all, and often it can be the most effective.

Suggested Reading

Alexander, F.: *Psychosomatic Medicine*, New York, W. W. Norton & Co., Inc., 1950, p. 142.

Gressel, G. C., et al: *Personality Factors in Arterial Hypertension*, J. Am. M. A. 140:265 (May 21) 1949.

Hambling, J.: *Psychosomatic Aspects of Arterial Hypertension*, Dig. Neurol. and Psychiat. 20:204 (May) 1952.

Schroeder, H. A.: *Hypertensive Diseases*, Philadelphia, Lea & Febiger, 1953, p. 376.

Shapiro, A. P., et al: *Relationship Therapy in Essential Hypertension*, Psychosom. Med. 13:140 (May-June) 1951.

Weiss, E.: *Emotional Factors in Cardiovascular Disease*, Springfield, Charles C Thomas, Chap. 6.

Book Reviews

● **THE SIX SCHIZOPHRENIAS, REACTION PATTERNS IN CHILDREN AND ADULTS**, by Samuel J. Beck, Ph.D. Research Monographs No. 6, published by The American Orthopsychiatric Association, Inc., New York, 1954, 238 pages, \$5. The results of two researches on schizophrenia are reported in this monograph. The studies were conducted at the Michael Reese Hospital in Chicago, during the period from 1947 to 1952 through grants from the National Institute of Mental Health, Department of Health, Education and Welfare. Collaboration of psychiatrists, psychologists, and social workers made possible these descriptions of schizophrenic behavior that could be clinically demonstrated and scientifically tested. From the coordinated findings six reaction patterns were discernible which are described in this volume. There are 12 chapters, of which the introductory one was written by Roy R. Grinker, M.D. and the chapter on the Q-technique and the Rorschach test by William Stephenson, Ph.D. In chapter three

the minutes of one research conference are given in full, as an example of the procedure. Thirty-five bibliographic references were used and cited, and an additional 95 are included. The volume is indexed and the test data are in the appendices. An outline index of the evaluation of Rorschach test behavior in schizophrenia is also given.

The initial step in this program was the analysis of a series of normal adults and children for purposes of comparison. Next came the analysis of the known schizophrenics, their clinical histories, and test results. The psychologic and psychiatric data were then correlated. Of especial interest to readers of THE PSYCHIATRIC BULLETIN will be the comparison of childhood and adult schizophrenias, the reemphasis as demonstrated by this inquiry of the indispensability of clinical investigation and social work, and in the final chapter, the breakdown into nine topics of the findings that constitute the contribution of these researches to the problem.

● **PROGRESS AND PROBLEMS IN MENTAL HOSPITALS**, Proceedings of the Fifth Mental Hospital Institute, edited by Daniel Blain, M.D. and Stella B. Hanau. Published by The American Psychiatric Association, 1953, 204 pages, \$2.50. The Fifth Mental Hospital Institute was held October 19-22, 1953, at Little Rock, Arkansas, under the auspices of the Mental Hospital Service of the American Psychiatric Association. The reported proceedings include an address by Kenneth E. Appel, M.D., ten plenary sessions, and summaries of the four group sessions. The volume has a detailed index and a geographical roster of the institute.

The topics under discussion in the plenary sessions were: administration, follow-up studies, effectiveness of therapies, legal aspects, architecture for geriatric hospitals, hospital activity programs, job placement and training for patients, testing and approval of clothing and laundry equipment, and training and research in state mental health programs.

THE USE OF physiological means to treat patients with functional illness is as old as the healing profession. Clinically effective methods, however, have practically all been developed in the past two decades. In spite of the intensified research in the fields of neurophysiology, pharmacology and psychology the two most widely used physiological methods of treatment in psychiatry were discovered empirically by clinicians.

Under the general heading of "shock treatment," a woefully unfortunate and misleading choice of terms, are included insulin coma therapy, convulsions induced either pharmacologically (Metrazol) or by electrical stimulation, and the more recent nonconvulsive techniques such as electronarcosis. The use of insulin will be discussed in a future issue of THE PSYCHIATRIC BULLETIN.

Electro-convulsive therapy, usually referred to as electroshock or EST, is technically a refinement and modification of convulsive therapy using Metrazol as the convulsant agent. In the *London Medical Journal* of 1785, W. Oliver reported the successful use of *camphor* in treating a case of "mania." Exactly 150 years later L. von Meduna used 25 per cent camphor in oil injected intramuscularly to produce convulsions. He had reasoned from the empirical observation that schizophrenia and epilepsy rarely occur in the same patient, and in patients with both afflictions a spontaneous convulsion often appears to be followed by improvement in the psychosis. Although the premise from which von Meduna reasoned is disputed by some, he *did* obtain clinical improvement in a high percentage of his patients. Because of technical difficulties in using camphor in oil, he next employed the synthetic camphor preparation *pentamethylenetetrazol*, known in this country as Metrazol, and already in wide use as a cardiac stimulant.

In 1937, U. Cerletti, of Rome, Italy, conceived the idea of substituting electrical stimulation for the pharmacological stimulation of Metrazol. With the technical assistance of L. Bini he conducted a series of experiments, using pigs as the laboratory animal, to prove that electrically induced convulsions are



feasible and safe. Cerletti has given a dramatic firsthand account of the first electro-convulsive treatment given a human patient, in Rome in 1938. The patient, a severe psychotic who was mute and completely out of contact, responded gratifyingly by awakening from the first treatment fully lucid; he lapsed back into his psychosis, in the same pattern now so familiar clinically,

but the effect seemed to be near-miraculous to those first observers.

Many technical refinements and modifications have been made in the instruments used for electro-convulsive therapy. The general aim has been to achieve clinical improvement with a minimum of the transient memory disturbance and confusion that these treatments always produce. Smoother and more



shock
py



gradual induction of the convulsive seizure is also desirable.

Mode of action

Though many plausible theories have been advanced, the actual mode of action of convulsive therapy is still unknown. It has been demonstrated that sub-convulsive reactions, either with Metrazol or electrical stimulation, are not only clinically

ineffective but actually tend to produce a state of severe apprehension and anxiety. From this and other observations it is felt that the actual convulsive seizure is somehow essential to the therapeutic effect. Since transient anoxia is an undeniable part of the reaction, patients often become alarmingly cyanotic, and attempts have been made to duplicate the effect of convulsive therapy

by producing anoxia by other means. Inhalation of nitrogen is one method, but so far all these attempts have failed to prove effective clinically.

There is clinical evidence of mild to moderate "organic" brain damage following a series of convulsive treatments. The EEG shows alterations that may endure six months or longer, and sensitive psychological tests reveal evidence of defect similar in nature to that seen in cortical disease. Yet for practical purposes these effects are always transient and in most patients they clear up in a few weeks. Some patients have received over 200 treatments over a period of a year or two with no clinical evidence of any lasting harmful effect.

Quite a few workers have seriously proposed that the principal therapeutic effect is psychological in nature. One such theory holds that the treatments gratify a need for punishment; another idea proposes that the treatments constitute an overwhelming threat calling forth a maximum response of the individual's integrative and self-preservative resources.

The facts of clinical observation, in the opinion of most experienced therapists, are not fully accounted for by any of the present theories. Practically all are agreed that the present method is a crude and unrefined method of obtaining therapeutic results that will some day be replaced by more precise and delicate techniques.

Risks

The risk to life in convulsive therapy is surprisingly small. The over-all death rate is about 0.06 per cent or 6 per 10,000. In many clinics mortality rates as low as 0.03 per cent have been reported for large series of patients. This is a lower risk than most minor surgical procedures requiring an anesthetic. Commonest cause of death is cardiac arrest; coronary occlusion and cerebral vascular accidents comprise most of the balance. Rarely a shock-like circulatory collapse occurs, particularly in severely agitated patients who have virtually exhausted themselves prior to treatment.

Musculoskeletal injuries are the most important nonfatal complications. Mild compression fractures of

a dorsal vertebra are very common with the conventional techniques. Except for transient local tenderness, these fractures practically never produce symptoms and are of primarily medicolegal interest. Fractures of the long bones, principally femur or humerus, are not rare and as would be expected are more prone to occur in patients with osteoporosis or in the elderly. Almost all patients experience some muscular soreness during a course of treatment. Recent advances in the use of muscle relaxants such as curare and succinyl choline chloride (Anectine) show promise of greatly reducing the risk of musculoskeletal injury. Injuries to teeth, lips, or tongue are comparatively inconsequential but may be largely avoided by the use of suitable mouth-gags. There are a few reported instances of spontaneous pneumothorax, of ruptured abdominal viscus, and of hemiplegias from cerebral vascular accidents, but these are extremely rare.

Contraindications

There are no absolute physical and/or organic contraindications to convulsive therapy. In many disturbed psychotic patients, the risk to life may be far greater from the untreated psychosis than from treatment. For example, a patient who has had a recent coronary infarction and who is agitated, hyperactive, and sleepless may well stand a better chance for survival with convulsive treatment. In less extreme circumstances, a recent coronary infarction would be a relative contraindication. Surprisingly, many authors have reported that their cardiac deaths more often occurred in patients who had no known pathological cardiac condition prior to treatment; on the other hand any large clinic could furnish an impressive series of patients with severe cardiac conditions who have received electro-convulsive treatment with no harmful effects.

At one time, active tuberculosis was felt to constitute an absolute contraindication. Recently it has been shown that improvement in the psychiatric illness usually facilitates improvement in the lung disease. With the new relaxant drugs, patients with fresh fractures and also postsurgical patients of all

categories have been successfully treated. The problem is essentially the same in all instances, that of weighing the possible physical risk of treatment against the possible risks of the psychiatric illness itself.

Indications

The principal indications for convulsive treatment are in the "functional" psychoses, schizophrenia, manic-depressive reactions, and the so-called involutional psychoses of middle and later life. In general, shock treatment is used when the patient's grasp of reality is so distorted that he cannot be effectively reached for psychotherapy. Severe agitation or manic excitement, catatonic withdrawal or depressive stupor, strong suicidal urges, and malnourishment due to refusal of food, may constitute virtual emergency indications for convulsive treatment. Depressive reactions are most likely to show favorable clinical response, particularly where the patient shows a general physiological slowing down, insomnia with nightly awakening around 3:00 to 4:00 A.M., and daily "mood swings" with the deepest depression occurring in the morning hours. Manic reactions tend to respond more slowly and show a higher percentage of treatment failures than do depressive reactions. Among the schizophrenic reactions, the more acute and explosive the onset the more likely is the patient to show improvement with shock treatment. Even under the most favorable conditions the remission rate is much lower in schizophrenia than in manic-depressive disorder. The longer the duration of illness prior to treatment, the less favorable the prognosis in schizophrenia. This does not hold for affective disorders.

Most authorities agree that convulsive therapy is harmful or at least ineffective in the neurotic reactions. The main disagreement concerns the so-called reactive depressions, i.e., depressive symptomatology in reaction to some traumatic experience (death of a loved one, financial loss, broken engagement). Reactive depression is similar to normal grief, but is pathologically intense or prolonged or both. Many patients exhibit depressive symptoms secondary to their neuroses and the

physician must avoid the snare of confusing depressive *symptoms* with a depressive *reaction*. A few authorities claim that true depressive reactions usually respond well to convulsive treatment but a great number of psychiatrists feel that psychotherapy is the treatment of choice. It would seem evident that shock treatment cannot give a patient any increased understanding of himself or any added strength with which to meet future life problems. In fact, electroshock therapy may harm the neurotic patient by adding to his anxiety. The patient's anxiety centers around his loss of self-esteem by being subjected to treatment usually reserved for persons who have "lost their minds." It has been well demonstrated by clinical fact that remission with shock treatment offers no protection against relapse or recurrence of illness. The majority of psychiatrists feel that shock treatment should be augmented by psychotherapy, environmental manipulations, and other therapeutic measures whenever the patient becomes accessible to such measures.

In recent years convulsive therapy has been used in the treatment of patients with severe agitation, depression, or excited states associated with arteriosclerosis or senility. Some patients with toxic psychoses have been treated symptomatically with electroshock during periods of intense agitation and excitement. These applications of convulsive treatment require skilled clinical judgment and usually involve somewhat increased risk.

Since its introduction, convulsive treatment has been tried in the treatment of alcoholism, homosexuality, the sociopathic or psychopathic reactions, and practically all the so-called personality disorders. There has been no evidence to justify its use in any of these conditions.

In properly selected cases, convulsive therapy is of enormous value and may greatly shorten the length of illness. Yet it is far from being a panacea for all emotional illness.

Suggested Reading

- Diethelm, O.: An Historical View of Somatic Treatment in Psychiatry, *Am. J. Psychiat.* 95:1165 (March) 1939.
- Diethelm, O.: Treatment in Psychiatry, New York, Macmillan Co., 1951.
- Kalinowski, L. B., and Hoch, P. H.: Shock Treatments and other Somatic Procedures in Psychiatry, New York, Grune and Stratton, 1946.



● The author presents a few common psychosomatic conditions in children and discusses some aspects of therapy. Psychosomatic illness is defined as the response of the vegetative nervous system to emotional states, as contrasted with conversion reaction in which the symptom represents a distorted expression of unconscious ideas and feelings.

In commenting on the child-parent relationship, he points out that the younger the child the more important this relationship is in producing symptoms. Cases including gastrointestinal, cardiorespiratory, metabolic, genitourinary, and mental retardation symptoms are discussed from the standpoint of symptomatology, etiology—both physical and emotional—and the therapy directed at these two phases.

In children under five years of age, the emotional phase of the illness may respond when treatment is directed solely to the parents. In older children, where physical as well as emotional treatment is needed, it is advisable to have the general practitioner handle the parents and the physical aspects of the disease, while another physician carries out the psychiatric treatment of the child. The reason for this is that painful physical treatment causes the average child to fear or dislike the doctor. This makes it impossible to gain his confidence for discussion of emotional problems.

Many physicians feel that they must do or give something tangible or their treatment is no good. They feel uncertain; therefore, they are ineffective in discussing the emotional aspects of the illness. Parents may tend to resist emotional factors when their child suffers obvious physical disorder. Reticence of children in discussing feelings in a way the physician can grasp may lead to hostility in him and only increase his difficulties.

Unnecessary bluntness in telling parents that their attitudes are factors in producing the child's illness increases their resistance to these factors, so that they ignore the physician's advice or go elsewhere. Many physicians feel that emotional subjects are not within their scope, and therefore do not discuss them. This leads to a continuation by the parents of their pathologic patterns of behavior in dealing with the child.

Finch, S. M.: Psychosomatic Problems in Children, *The Nervous Child* 9:261, 1952.

● The author discusses the psychological mechanisms used in menticide or brain washing. Russian psychiatry is based entirely on orthodox Pavlovian principle, the Soviet agencies accepting the fact that man can be conditioned and trained just as the Pavlov dogs were. Their aim is to train and indoctrinate men into a society of "human insects among

whom every pattern of behavior is prefabricated."

According to Pavlovian psychology, human speech is conditioned reflex activity. Stimuli of the first order are direct and fairly simple while stimuli of the second order are weaker and more complicated. In the so-called second signal system, verbal cues replace physical ones.

Tone and sound of the word is used first as a conditioning quality and later its symbolic and semantic meaning are used. Pavlov discovered that man even more than animals is related to the world primarily by secondary stimuli, that is, by the speech symbols in which he learns to think. Thus his behavior may be partially controlled by conditioning his reaction to these symbols.

Conditioned behavior is very important in totalitarian plans for political control and is not to be confused with persuasion and indoctrination. It means actual possession of the complicated nervous patterns of mind. The victims are conditioned to react to catch-words, verbal stereotypes, slogans, and symbols rather than to reality. Imprinting these prescribed reflexes on a mind that has been broken down is relatively simple by Pavlovian strategy.

The system starts with verbal conditioning by combining the required verbal stereotype with negative stimuli such as pain or hunger, and positive stimuli such as food, better

treatment, etc. According to prisoners of war in Korea, hunger and food were the negative and positive stimuli most often used, but there were also physical and moral pressures, chemical pressures (drugs), boring repetition, and confusion created by seemingly logical syllogisms. Mental breakdown was carried out systematically by first instilling fear and isolation, provoking guilt and masochistic submission. Rewards were given for "correct" behavior and answers.

The author points out that some conditioning occurs in any society and that even democracies must guard against a compulsive regimentation in schools. He feels that children reared to be unquestioning, servile and dependent, who are made to feel continually guilty, cannot develop the questioning frame of mind, initiative and freedom which safeguard against conditioning. Goal-directed behavior in man opposes conditioned behavior. Even in animals, spontaneous affection for the laboratory workers spoiled the Pavlovian experiments when it caused sudden loss of all the conditioning signs—a point that escaped the Russian observers.

Meerloo, J. A. M.: Pavlovian Strategy as a Weapon of Menticide, *Am. J. Psychiat.* 110:809 (May) 1954.

● This article sets forth the method, effect and treatment of brain-washing or coercive political indoctrination in a group of returning prisoners-of-war. Struck by the emotional isolation and apathy of the returnees in operation "Little Switch," a period of re-orientation

and readjustment was necessary to "bridge the emotional gap between prison and home." Return by ship afforded the interlude necessary for this integration, which was aided by group sessions before embarkation and during the trip home.

The repatriates were enlisted men below the rank of corporal, averaging less than 25 years of age and of generally limited educational background. Most had been prisoners-of-war for more than three years. Their experiences could generally be divided into two basic components. The first was one of marked physical privation and abuse at the hands of North Koreans; the second was characterized by the emotional stress of the Chinese indoctrination program. "Death marches," deprivation of food, clothing and medical care, vicious beatings and brutal killings of fellow prisoners were common experiences. The initial reaction to this was great anxiety and some belligerence; later, there was emotional withdrawal, depression, and apathy. By October, 1951, Chinese forces instituted better physical conditions and began the program of "brain-washing."

This emotional assault consists of three constant and simultaneous operations: isolation, thought control, and political conditioning. Isolation was carried out by removing commissioned and noncommissioned officers, discouraging close personal bonds, giving material rewards for spying on fellow prisoners, undermining identification with family, religion, country, etc. The technique for thought control usually included veiled threats of physical harm, non-repatriation, "logical" persuasion

and stimulation of guilt feelings for previous actions.

Political conditioning was carried out by lectures and compulsory group discussions, all characterized by repetitious teaching of Communist ideas and catch-words, denunciation and exclusion of opposing ideas, arbitrary and authoritarian concepts of truth and error. Throughout this program of intensive pressures, there was a system of rewards for "cooperation" and punishments for resistance, as well as skillful manipulation of the group to control its reactions.

Behavior of the Communist authorities was unpredictable—alternating harshness, kindness, friendliness, and threats, but never trustworthy. The soldiers developed the same attitudes seen in children of inconsistent, demanding parents—that is, guilt, confusion, attempt at withdrawal and conflicts as to how to behave. Most men learned to "play it cool"—i.e., concealing strong feelings, "cooperating" just enough to get along and establishing some point beyond which they would not go in collaboration. Only a relative few avoided some form of cooperation with the enemies. One was the well-integrated personality with a strong sense of identification; another had a life-long pattern of acting out against all authorities. Anxiety and desire for material gain were important factors leading to collaboration. Strong political beliefs appeared to be of little importance.

On release, prisoners appeared to be confused, unenthusiastic, vague, lacking in spontaneity and affect. Suspicion and guilt were marked. The guilt concerned all phases of



the prisoner-of-war experience from capture to survival, but was most strongly felt in the area of cooperation, no matter how inconsequential. Feelings toward the Chinese were ambivalent, indistinct and mildly expressed. Most had difficulty in accepting the realities of repatriation. Aboard ship at first they were sluggish; some enjoyed special treatment but others objected as it increased their feelings of helplessness. They tended to exclude non-returnees as "not having been with us up there."

Within a few days at sea, gradual but increasing emotional reaction in the form of belligerence, irritability and complaints was noted. In psychiatric sessions, expressions of hostility became more direct, especially toward the Chinese; but most returnees were unable to deal in a group with their prison experiences, particularly the guilt-laden aspects of them. There were tremendous feelings of isolation, inability to communicate, and anxiety about the future. Dependency needs were prominent, frequently being expressed in the form of denial. Apprehension, fear, and guilt about Communism remained. Most arch-reactionaries maintained a martyred attitude and participated only minimally in the group therapy. "Progressives" achieved considerable catharsis, their strong guilt feelings making the sessions welcome.

Apathy as a defense against disturbing environment was very prominent in prisoners of World War II. In the Korean War, the indoctrination program constantly exerted pressure for participation, making withdrawal impossible as a successful defense. These men had to walk a "behavioral tight-rope" complicated by anxiety and guilt. The transition from apathy to hostility was regarded as a favorable sign. Of great importance is the fact that men in each group had been sufficiently conditioned so that their prison-camp responses persisted even in the new situation. Most failed to make strong group identification prior to capture. Afterwards, shifting camps and prisoners, and lack of officers prevented formation of group feelings. Captors avoided direct brutality or hostility which could stimulate strong group resentment and act as a

cohesive force, and individual isolation prevailed. Thus the only common identity available to these men was that of repatriated prisoners-of-war. It was the only strong here-and-now tie and was used to fill the emotional vacuum experienced by these men.

The author feels that this tremendous isolation and lack of group identification will affect these men in their future adjustment. It may take such forms as paranoid reactions, confused identification, and inability to participate in future military or civilian communities. Certain men will exaggerate their prisoner-of-war identification as a buffer and rationalization to all future adjustment problems.

Lifton, R. J.: *Home by Ship: Reaction Patterns of American Prisoners of War Repatriated from North Korea*, *Am. J. Psychiat.* 110:732 (April) 1954.

● Clinical, psychiatric, and experimental investigations point to essential hypertension as a psychosomatic disease; but the role of the emotional component is poorly understood. Analytically-oriented studies show frequent and important emotional disorders in the hypertensive. It is believed that these problems stem from lifelong conflict between repressed aggression and hostility and even more deeply repressed wishes for dependence and security. Real or threatened frustration of the dependency strivings leads to increased hostility, which requires more repression. These patients often appear calm, self-controlled, and lacking in self-assertion.

Nonanalytic observers stress the element of suppressed anger and lack of normal assertiveness, but say little regarding the underlying dependent needs. Both agree that elevation in blood pressure is probably connected with the patient's unexpressed hostility in an unexplained manner.

It is as yet unproved that most hypertensive patients have undue emotional disturbances and that the hypertension generally centers around the factors mentioned above. Too few cases have been studied; those investigated have either been picked at random or sent for psychiatric consultation because of overt emotional difficulties. Control groups

have not been used, and no precautions have been taken to guard against bias and preconceptions of the investigators.

Gressel and co-workers studied hypertensive and control groups; they concluded that there was a significant correlation between hypertension and obsessive-compulsion behavior, and subnormal assertiveness. Impulsiveness and anxiety showed no such correlation. The positive correlation existed in hypertension of renal origin. This admittedly small study shows certain types of emotional patterns to be more frequent in hypertensive groups than in matched controls suffering from organic disease or psychoneurosis.

Weiss and his group, in incomplete studies of 150 hypertensives, found no specific personality structure or conflict but did frequently encounter psychologic patterns which correspond closely to analytic data.

The claim that hypertensive patients are nervous because they are sick is not borne out by 100 case histories before and after onset of the disease. This review showed that complaints of nervousness preceded the elevated blood pressure in most of the patients.

No reliable evidence correlates the onset of hypertension with preceding or concomitant emotional stress. Evidence linking its exacerbations and remissions with variations in the patient's life situation is more convincing. Reiser and his group had twelve cases showing the onset of the malignant stage of the disease while the patients were experiencing serious difficulties in their living. He concludes, from these and a larger number of less severe cases, that the course of the disorder appeared to be affected when unresolved major conflict could not be handled through normal channels of behavior.

Benedict states that psychotherapy has not been shown to alter the natural course of hypertension, but is of value in controlling many of its symptoms. This failure does not invalidate observations linking emotional disturbance and high blood pressure.

Benedict, R. B.: *Psychiatric Concepts in Essential Hypertension*, *Medical Annals of the District of Columbia* 23:197 (April) 1954.



ENCEPHALITIS

& its sequelae

in children

ENCEPHALITIS should be considered as a possible etiologic factor when a child exhibits "animal-like" behavior. This behavior is represented by the extremely hyperactive, restless, destructive child with a short attention span — a child who is highly distractible and lacking in self control and whose behavior is extremely unpredictable.

Incidence

Greenebaum and Laurie examined the cases of 2,700 children presenting all types of behavior problems. Of these 2,700 children, 78 or 2.85 per cent were found to have behavior problems of postencephalitic etiology. In the 78 children studied, 61 were boys and 17 were girls; a ratio of 4½ to one. This agrees with the two to one ratio reported by other investigators. The authors feel that behavior and personality changes associated with acute infections in contagious diseases are frequently overlooked. Consequently, the child's history must be carefully scrutinized in order to relate the behavior to the possible encephalitic episode.

Encephalitis and infectious diseases

Nearly any acute infectious disease may at times be associated with symptoms indicating involvement of the central nervous system. Lack of uniform manifestations suggests that the process is non-specific.

In certain of the exanthemata, there are well defined pathological and clinical pictures. Encephalitis of this type often occurs after measles, rubella, variola, vaccinia, varicella, and febrile illnesses of unknown origin. It is most common in measles, and there is a suggestion that this is increasing in frequency. The incidence in 1937 was 1:15,000 as pointed out by Litvak; by 1941 it had risen to 1:1000 and in 1951, Shaw found an incidence of 1:616 cases. In smallpox the incidence of encephalitis has been estimated at 1:2000. Complications of varicella and rubella are much smaller. Meningeal involvement in mumps is probably fairly common but fortunately the damage to brain tissue and the vascular bed is minimal. The pathogenesis in this group of encephalitides is unknown but two major theories are usually considered: (1) that the encephalitis results from the

virus causing the associated illness; (2) that the brain reponse is the result of an antigen-antibody reaction.

Whatever the pathogenic mechanism is, the clinical picture usually falls into one of three main types: meningo-encephalitic, encephalitic, or encephalomyelitic.

Meningo-encephalitic type: The patient presents symptoms of meningeal irritation: headache, vomiting, stiff neck, and stiff back. There may be cranial nerve weakness and moderate to profound drowsiness.

Encephalitic group: Presenting signs and symptoms are directly attributable to involvement of the brain itself. The most prominent symptoms are convulsions, coma, and cranial nerve weaknesses.

Encephalomyelitic group: These patients may exhibit both brain and spinal cord involvement. The clinical findings will depend on what part of the cord is involved. Paraplegias, monoplegias, etc., are frequently found and the cord involvement may dominate the picture.

Prognosis varies according to the associated disease. With regard to measles, the mortality rate may range from nine to 45 per cent; the sequela rate has been reported as high as 45 per cent also. The prognosis in varicella is better than in measles and in mumps is usually considered good.

Epidemic encephalitis

This disease may occur at any age from early infancy to late life. The etiologic agent is not known. The outstanding pathological changes are in the midbrain and basal ganglia although any part of the central nervous system may be affected, resulting in an almost unlimited variety of clinical manifestations.

Encephalitis may begin abruptly or be ushered in with prodromata of headache, stomach-ache, pain in the extremities, irritability, upper respiratory infections, and mild meningeal symptoms.

The disease itself seems to fall into one of three patterns: lethargic-ophthalmoplegic, irritative-hyperkinetic, and atypical forms.

Lethargic-ophthalmoplegic form: This form is characterized by somnolence and ocular palsy. The patient may sleep for days or weeks. The depth of sleep may vary from

drowsiness to coma. Delirium may accompany the lethargy and hallucinations may occur. Ptosis, strabismus and nystagmus are not unusual. Involvement of the ocular nerves occurs in 50 to 90 per cent of the patients; seventh nerve palsies are next in reported frequency. Although the lethargic state is usually a single episode, it may take a relapsing form.

Irritative-hyperkinetic form: Patients may develop this form as the only initial feature of encephalitis. But the irritative-hyperkinetic form occasionally emerges from the lethargic state. Abnormal muscular contractions range from tics to convulsive seizures. Choreiform and athetotic movements are seen. The disorder may be restricted to individual muscles or involve only a single limb, but can affect one side of the body, or the entire body.

Atypical forms: These forms of encephalitis deviate widely from the classical patterns. The acute stages may be so mild and unobtrusive as to make diagnosis impossible until the typical sequelae appear. Overtalkativeness and overactivity may follow the acute stage. Following his recovery from the primary disease, the patient may develop a variety of neurologic, metabolic or mental symptoms. These symptoms are the result of the original damage.

Other forms of encephalitis

In addition to the two types discussed above, there are the encephalides caused by tubercule bacilli or Treponema pallidum and those accompanying poliomyelitis, or rabies. Another type, termed encephalopathy, may result from physical trauma, toxins, or deficiency diseases.

Postencephalitic syndromes

Postencephalitic syndromes may fall into three groups: (1) neurologic: Parkinsonism, hyperkinesia, paralysis, convulsions. (2) vaso-vegetative: endocrine syndrome, vasomotor disorders. (3) psychologic: behavior disorders, intellectual deficit.

Neurologic group: Neurologic abnormalities were seen in all except 22 of the cases reported by Greenebaum and Lurie. These involved both pyramidal and extrapyramidal systems. Ocular symptoms were present in 16 patients. Three children had petit mal attacks, six had

grand mal seizures, and seven had symptoms of Parkinsonism. Electroencephalograms were done on 15 patients. Of these, eight showed abnormal tracings typical either of epilepsy or generalized cerebral dysrhythmia, a characteristic of psychomotor disturbances.

Parkinsonism develops in about 50 per cent of encephalitic adults but is less frequent in children. During the acute stage some degree of rigidity and mask-like facies may be seen but these usually recede to the normal. Later, typical paralysis agitans develops. Prognosis for the Parkinsonism group is not favorable.

Tics, choreiform and athetoid movements are principal hyperkinetic sequels. These may be twitching of the shoulders, grimacing, spitting, picking at the nose, puffing and sighing. Respiratory disorders of rate and rhythm or tics such as yawning, hiccups or spasmodic coughing are seen. Oculogyric crises are much less frequent in children than in adults. Another outstanding characteristic of postencephalitic children is an "organic drivenness." These children are constantly on the move in either purposeful or aimless behavior.

Vaso-vegetative sequelae: A rapid gain in weight is usually the first indication of the vaso-vegetative process. Other residua which have been reported include diabetes insipidus, dystrophia adiposo-genitalis, sexual precocity, and severe hypertrichosis.

Psychological sequelae: Children with these postencephalitic effects are difficult to handle. Alteration of the personality occurs following the acute stage of the disease. In most instances, the child's parents and teachers fail to connect the personality and behavior changes with the encephalitic episode. Even stranger is the fact that the physician and



the psychiatrist sometimes fail in this respect also. Children normally manageable and conforming, become restless, intractable, and manifest antisocial tendencies. They become aggressive, explosive, and rapidly change their goals. This behavior makes adherence to routine impossible and the child's school work suffers even when he has sustained no intellectual damage. Rage reactions and the use of profane language are not uncommon. The child may lie, steal, or wander away from home. Punishment or reward have only temporary effect. The children *do* recognize their misbehavior and apologize for it, often saying that they cannot help it. Their regrets and promises for reform are only transitory and the impulsive behavior continues. The affect is very labile and moodiness and hostility alternate with tenderness and contrition. Sex delinquency is fairly common. Paranoid trends may develop. The behavior bears no direct relationship to the severity of the physical condition except that a slowed, Parkinsonian child exhibits less drastic and violent behavior.

Intellectual loss occurs in some children. Kanner is of the opinion that impairment of intellect can be shown by Binet test in the majority of cases, particularly if the disease occurred during the first two or

three years of the child's life. When encephalitis occurs later in life, there is further, partial development of intellect and capacities while some previous acquisitions drop out. Greenebaum and Lurie found that the abnormal behavior fell into three general types: simple behavior disturbances, psychopathic behavior, and psychotic reactions.

Simple behavior disturbances included restlessness, hyperactivity, and temper tantrums. The children were noisy, domineering, aggressive. Lying, stealing, truancy and enuresis were frequent.

Children in the *psychopathic group* gave the impression of being intellectually dull although tests revealed normal or even above normal I.Q.'s. They were asocial, concentrated poorly, and were either unwilling or unable to carry out instructions. They too were extremely restless and hyperactive. Their behavior was often deliberately vicious, cruel, and abusive to other children and their unpredictability was outstanding. Night terror, sleep walking, breathing difficulties and habit tics were also seen frequently.

The *psychotic group* was even more severely disorganized. In fact, the children were impossible to control. Their personal appearances and habits were slovenly. Moodiness, crying spells, irrelevant talk, outbursts

of screaming and senseless laughter were often present. Hallucinations were not uncommon.

Therapy

Reports of social and medical therapy are highly disappointing. Of the 78 cases reported by Greenebaum and Lurie, only twelve children were considered adjusted—nine boys and three girls. The authors believe that failure of social therapy and psychotherapy is not attributable to faulty technique but rather to the fact that the psycho-pathological symptoms are primarily the result of neuro-pathologic changes.

Phenobarbital tends to increase the symptoms but at times the anti-convulsant drugs—Dilantin, Mesantoin, Tridione, Phenurone, etc.—may be of help either alone or combined with the amphetamines. In the more severe cases, institutionalizing the child appears to offer the best solution for both him and his family.

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individual personalities are not rigidly restricted to either of these antithetical types at all times. Since this division expressed only the extremes of behavior in direct relation to environment and in secondary relation to environment, it had to be modified or expanded. Jung, therefore, further subdivided personality types into eight categories. These subtypes were predicated on introverted or extroverted relationships to four fundamental psychological functions. These basic functions were thinking, feeling, sensation, and intuition. In each of these functions the individual's attitude and consequently his behavior might be

preponderantly introverted or extroverted. Jung believed these personality types to be innate patterns of behavior. When any individual suppressed or reacted at variance with his basic inclinations, or, conversely, when he adhered too closely to such characteristics, abnormality resulted.

In 1948 the C. G. Jung Institute Zurich was founded, with a teaching staff instructed by Jung himself. The psychiatrist is now retired but he continues to direct the institute and to write on the subjects of his varied interests, such as alchemy and religious psychology. He and his wife, who is also a psychiatrist, live near Zurich, where

Jung fishes, writes, and sees hundreds of patients and admirers.

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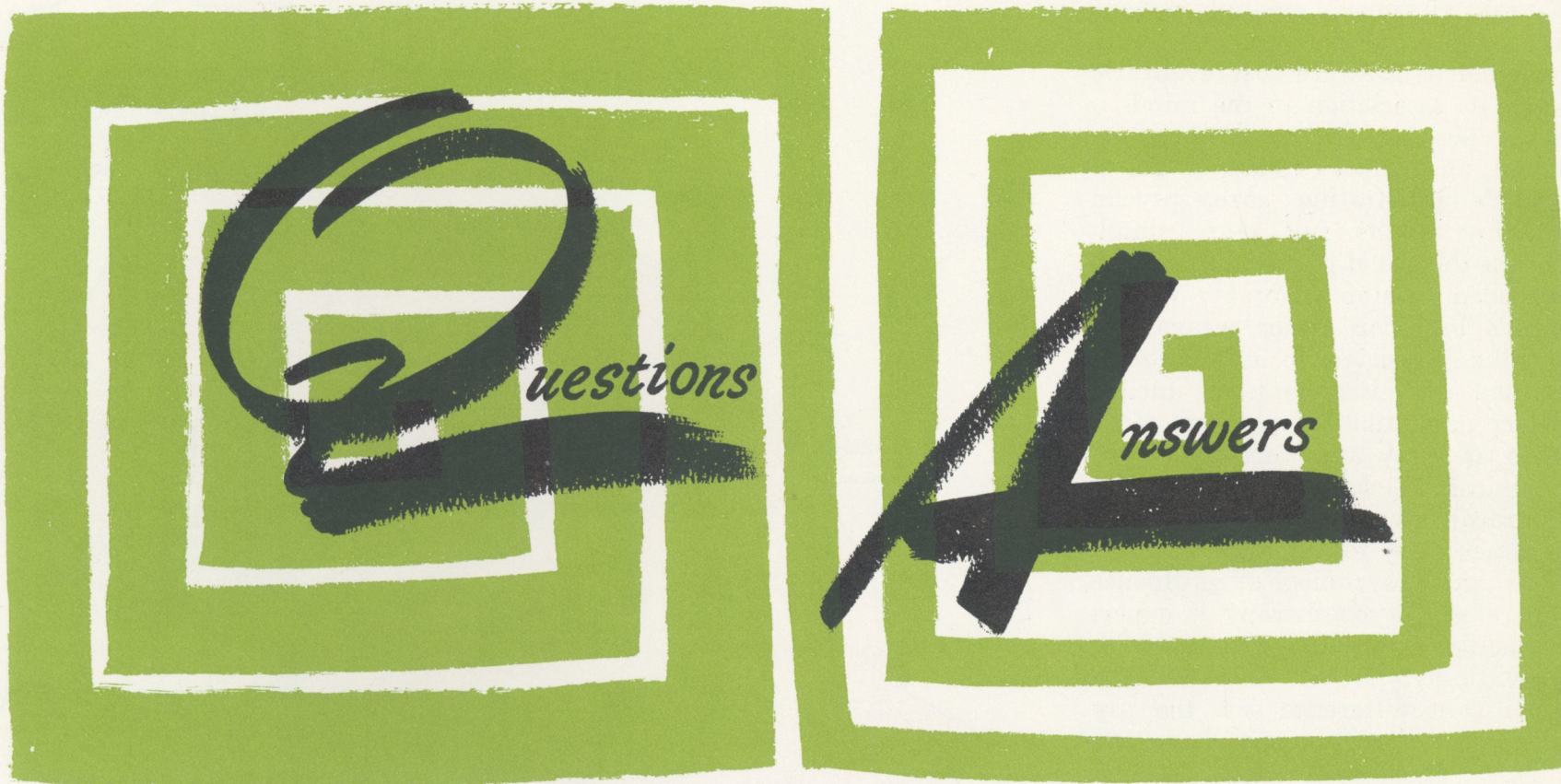
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QUESTION: What are the psychiatric theories dealing with frigidity in the female?

ANSWER: Psychoanalytic theories regarding sexual frigidity in the female have undergone considerable and progressive revision since Freud first propounded his formulations regarding "vaginal orgasm." Psychiatrists today are inclined to believe that no such thing as "vaginal orgasm" exists in the female. Orgastic potency is influenced by both physical and psychological factors, and when it is achieved it is a total reaction in the female, just as it is in the male. The earlier theory that the zone of sexual primacy shifted from the clitoris to the vagina with the attainment of sexual maturity is now in doubt. Anatomical and physiological studies reveal that there are no significant nerve centers located in the vagina, that the plexus of nerves concerned with erotic stimulation is centered in the clitoris and without adequate stimulation of this area, orgasm becomes increasingly difficult for the woman to attain. It is true that there is also a large psychological factor involved in the attainment of orgastic potency in the female. She is often psychologically hampered by feelings of guilt which attach to clitoral stimulation, since this area usually plays a

major role in the masturbatory practices of childhood. However, if she is helped to understand that the glans clitoridis in the female corresponds neurologically to the glans penis in the male, and is of major importance in adult sexual relations, this can be of considerable benefit. It will not help the woman of low sexual responsiveness to instruct her that the vagina is considered the only proper erogenous zone for sexual stimulation.

Reference: Marmor, J.: Some Consideration Concerning Orgasm in the Female, *Psychosomatic Med.* 16:240 (May-June) 1954.

QUESTION: How can a physician assure that his patient will follow through when referred for psychiatric treatment?

ANSWER: It is unfortunately true that many patients, particularly those suffering from psychosomatic disorders, will doggedly evade any attempt to provide themselves with psychotherapy at the hands of a specialist in psychiatry. According to Berlin, "it is estimated that more than 50 per cent of patients with psychosomatic disorders fail to follow through on referrals for psychiatric treatment."

In attempting to examine the reasons for this unbounded reluctance on the part of these patients, Berlin

reviewed his experience with referred patients over a period of five years. An attempt was made to determine the factors which influence the patient's decision to accept or to reject the proposed psychiatric referral.

The transference situation with the referring physician apparently is of prime importance in determining whether or not the patient will accept referral. Too often, the physician may fail to appreciate the degree of dependency involved in the patient's relationship with him.

From the patient's standpoint, a considerable investment may have been made already in establishing rapport with the physician of his choice. Once having acquired a warm and personal relationship with his "own" physician, the patient may be inclined to feel exceedingly rejected if an attempt at referral is made. This feeling of rejection can usually be forestalled, however, if the referring physician assures him that he will carefully follow the progress of his case. If the referral is referred to as "consultation," the patient will not feel that he has been dropped, and feelings of rejection are less likely to develop.

Reference: Berlin, I. N.: Some Reasons for Failures in Referral for Psychiatric Care of Patients with Psychosomatic Illnesses, *Ann. Int. Med.* 40:1165 (June) 1954.

EVERY PHYSICIAN treating patients is doing psychotherapy constantly, whether he is aware of it or not. Despite its association in the minds of some people with a semi-mystical ritual, an analyst's couch, or a hypnotist's penetrating gaze, psychotherapy in its full sense simply means the use of psychological forces intended to alter favorably the patient's behavior. Other means used by the physician to influence the human organism he treats include direct manipulation, physical forces such as x-ray and ultraviolet light, chemicals, biologicals, etc., and in appraising the effects of all of these it is necessary to recognize and evaluate the psychological influence. Therefore, psychotherapy is a part, explicitly or implicitly, wittingly or unwittingly, of all treatment. A significant difference sets the psychological forces apart from the others. This is the fact that the potency, and therefore the effect, of these forces depends on the emotional meaning and significance to the patient of what is being done. Whether it be a surgical procedure, an injection of some drug, or a subtle thing like a gesture or tone of voice, the psychological effect is determined by what it *means* to the patient, not by the physician's private judgment of his procedures. Any successful psychotherapy requires that this be kept in mind.

Psychotherapy may be arbitrarily divided into two fundamental types: (1) *deep* or *uncovering* therapy; and (2) *superficial* or *supportive* therapy. In the first type it is the aim of treatment to make the patient aware of his *unconscious* emotional conflicts and to eradicate the deepest sources of his neurotic or immature behavior. This implies an attempt to effect fundamental and far-reaching changes in the patient's emotional patterns, and therefore requires skills and techniques available only to the trained specialist. The second category, supportive therapy, has much wider application, and utilizes a number of techniques that virtually all physicians can master.

Although they merge into one another, there are several basic methods in which psychological forces may be used for supportive therapy. The following ones will be

considered in some detail: (1) establishing the relationship; (2) reducing environmental stress; (3) providing outlets for emotional energy; (4) direct interview-discussions with the patient.

Establishing the relationship

A painstaking, thorough history, followed by a methodical and complete physical examination, sets the stage for all future handling of the patient. These procedures are psychotherapeutic in themselves, and in addition enable the physician to be definite, positive, and to the point in appraising the patient's physical status. It is unwise to give an anxious, insecure person reassurance that he is physically healthy on the basis of snap judgment or cursory examination. Even if the physician feels certain in his own mind that a detailed examination will reveal nothing, he should reserve any statement of opinion until after the examination is done. Pertinent laboratory studies should of course be made, but except in instances where there is clear medical indication for them the physician should not yield to the patient's anxiety by ordering an interminable series of further diagnostic studies.

Having established a firm and reasonable basis for the patient's confidence in the physician's judgment, the next step usually consists of an informal discussion of the findings. Where there are no physical abnormalities, or where physical findings do not account adequately for the symptomatology, the physician may say something to the effect that a really complete examination requires looking into possible emotional causes for the trouble. A simply worded explanation of the physical components of emotion, using such common examples as blushing, fright, disgust, etc., helps put the patient at ease and promotes the



Supportive



psychotherapy

feeling his symptoms are considered *real*, not *imaginary*, even if he is physically sound. Good points of departure for this phase of discussion may have been noted in the history-taking. An attitude of "let's see what we can find out" pays off more than a flat "your trouble is only nerves." Once the patient has begun to talk about himself and ask some questions, the physician may be able to help a lot with plain factual information. Physicians have a great deal of knowledge about the normal or essentially insignificant variations in human behavior; daily use of this knowledge often leads them to take it for granted and to forget that

many patients, even highly intelligent and well-educated ones, may not have access to it.

Reducing environmental stress

Temporary measures to lessen responsibilities often give patients a chance to regain their equilibrium. The physician may be able to help in getting a temporary change in job duties, or he may prescribe a temporary arrangement for the care of children outside the home to relieve stress on the mother. In handling marital problems it is occasionally worthwhile to consider a brief separation for medical reasons, especially when both partners are being continually provoked to impulsive, retaliatory behavior. Sometimes a vacation or visit to relatives may help a patient, but in these instances the physician should have positive reason to believe a real reduction in stress will result before such is prescribed. Hospitalization is often useful for the sole purpose of getting the patient away from the disturbing environmental situation.

Sometimes a mildly depressed patient with some obsessional tendencies can be helped by prescribing a rigid daily routine, with some definite activity outlined for each

hour of the day. Indecision and vacillation often play a large part in such patients' disturbance, and they may be made more secure by being temporarily relieved of having to make decisions about anything.

A more lasting reduction in stress may be attempted by such devices as conferences with other important persons in the patient's life, encouraging understanding and promoting more healthy attitudes toward the patient. This is greatly relied on in handling emotional problems of children where the crucial work must often be done with one or both parents. Career changes, moving away from disturbing relatives, and similar moves also come in this category. However, these changes should be made only after the emotional situation is well surveyed and seem to serve a real therapeutic purpose, not merely an escape. The physician should suggest such changes only after as much consideration as he would employ before suggesting major surgery. It is always best to assist the patient in his own decision in matters of importance but there are times, especially in dealing with passive, indecisive patients when the physician may take a more authoritative stand.

Providing outlets for emotional energy

The goal here may be general or specific. Among useful devices for general emotional outlets are the time-honored occupational therapy, recreation, social activities, hobbies, and the like. Where the physician recognizes the predominance of a specific emotion he may be able to prescribe outlets for its expression in socially acceptable ways. For example, to drain off aggressive or hostile impulses such things as competitive sports, boxing, bowling, digging in a flower garden, etc., are often useful. A depressed patient with a lot of guilt feelings may get some relief from being assigned menial tasks which serve his need for self-punishment. A spinster with no outlets for her mothering impulses may be advised to do community work with children. Or the patient may be encouraged to develop compensatory skills and talents to counterbalance inferiority feelings. The physician himself, provided he is fully aware of it and

feels that self-reliance is unattainable for the patient, may foster dependency by taking a paternal, protective role; a specific need is thus served. Whenever dependency is encouraged, one must be prepared for a certain amount of illogical and potentially frustrating behavior on the part of the patient, who may proceed to "act out" with the physician some of the old emotional problems which he had experienced with his parents.

Actual interview techniques

The procedures outlined above have to do primarily with the patient's general life-situation. In the direct contacts the physician's principal role is that of a sympathetic, unbiased listener. Just having someone who will hear him out and not inject critical or moralizing comments may be a new and strengthening experience for the patient. Also, the physician, if he himself is reasonably mature, makes no emotional demands on the patient to complicate the picture—unlike most of the patient's usual contacts. Confession, ventilation, abreaction—all these terms are seen in psychiatric literature and essentially denote the process of "getting it off your chest." The physician should be aware that it is the expression of *feeling* which matters; the patient may feel better after an interview in which little of apparent significance was said but copious tears were shed; conversely, a disclosure of emotional problems related without expression of feeling may gain nothing even if it gives a "textbook picture" of intellectual understanding. With this in mind one should practice listening for the emotional content of what is being said. For example, with a patient who is obviously depressed and who is talking about being unable to get anything accomplished and having no interest in things, some comment like "you're feeling pretty low, aren't you?" is more apt to further the emotional abreaction than is a question directed to *what* was being said.

Going a step further than the "confessional" type of interview is a systematic study of present and past life situations in relation to symptoms. One is, of course, looking for some sort of pattern, and it is a

good general principle to try to let the patient make the discoveries himself. It may be obvious to the physician after one interview that Mrs. X's stomach upsets always occur after her mother-in-law's visits; if the patient does not see the connection spontaneously one should point it out *only* when it is felt the patient is close to realizing it *or* is emotionally ready to accept it. Here is a point where the art of psychotherapy comes in, in the sense of timing of interpretations.

In supportive therapy, interpretation actually plays little part. Sometimes the physician may suggest certain possible hypotheses to the patient, but he should do it in a tentative way and drop the point if it is not accepted. One would never interpret *unconscious* feelings of the patient; the more accurate such an interpretation the more devastating it is apt to be. It is a good general practice to shift the subject if the patient begins to show marked symptoms of anxiety of more than fleeting duration. It is necessary to respect the patient's reticence to go into certain areas of discussion, no matter how important the physician may feel the subject to be. Nothing of therapeutic value is ever gained by bulldozing or intimidating a patient into revealing material.

Even for the exceptionally mature physician it is next to impossible to do effective psychotherapeutic interviewing with a patient he does not like. Such situations of course do arise; if it is felt that interview therapy is necessary, one should refer the patient to someone else.

Selection of cases

Only broad general principles can be briefly outlined regarding the selection of appropriate cases for psychotherapy by non-psychiatrists. The general practitioner must often try to manage a patient he fully realizes should be referred. Where it is apparent that the care of a specialist is needed but for practical reasons one cannot arrange it, it is best to limit therapy to maintaining a friendly relationship, allowing the patient to ventilate his feelings, keeping the environmental stress to a minimum, and using mild sedative drugs judiciously. The severely depressed patient should be handled

by the general practicing physician only when it is impossible to make other arrangements, and the family should be warned of the ever-present suicidal risk. One should learn to detect the ambulatory schizophrenic and avoid any probing therapy with this group, since it is fairly easy to precipitate a panic state or an exacerbation of the psychotic process.

The major field of the general practicing physician for the use of psychotherapy is with essentially normal individuals undergoing acute emotional crises and with the mild to moderately severe neurotic reactions. Acute anxiety reactions, mild depressions, and the emotional reactions associated with somatic symptoms (digestive tract, cardiovascular system, etc.) are generally favorable cases. In estimating the patient's suitability for therapy one considers intelligence, previous level of adjustment, duration of symptoms, age, life situation, and degree of adaptability or flexibility. Sometimes one finds pathogenic factors in a patient's life situation that are simply unalterable, and there are undoubtedly times when the physician must accept the fact that the patient's neurosis is the best "solution" available. The goals of therapy would obviously be limited in a patient with a fixed, unchanging pattern of symptoms of many years' duration, or in a patient who had never succeeded in approaching an adult level of adjustment.

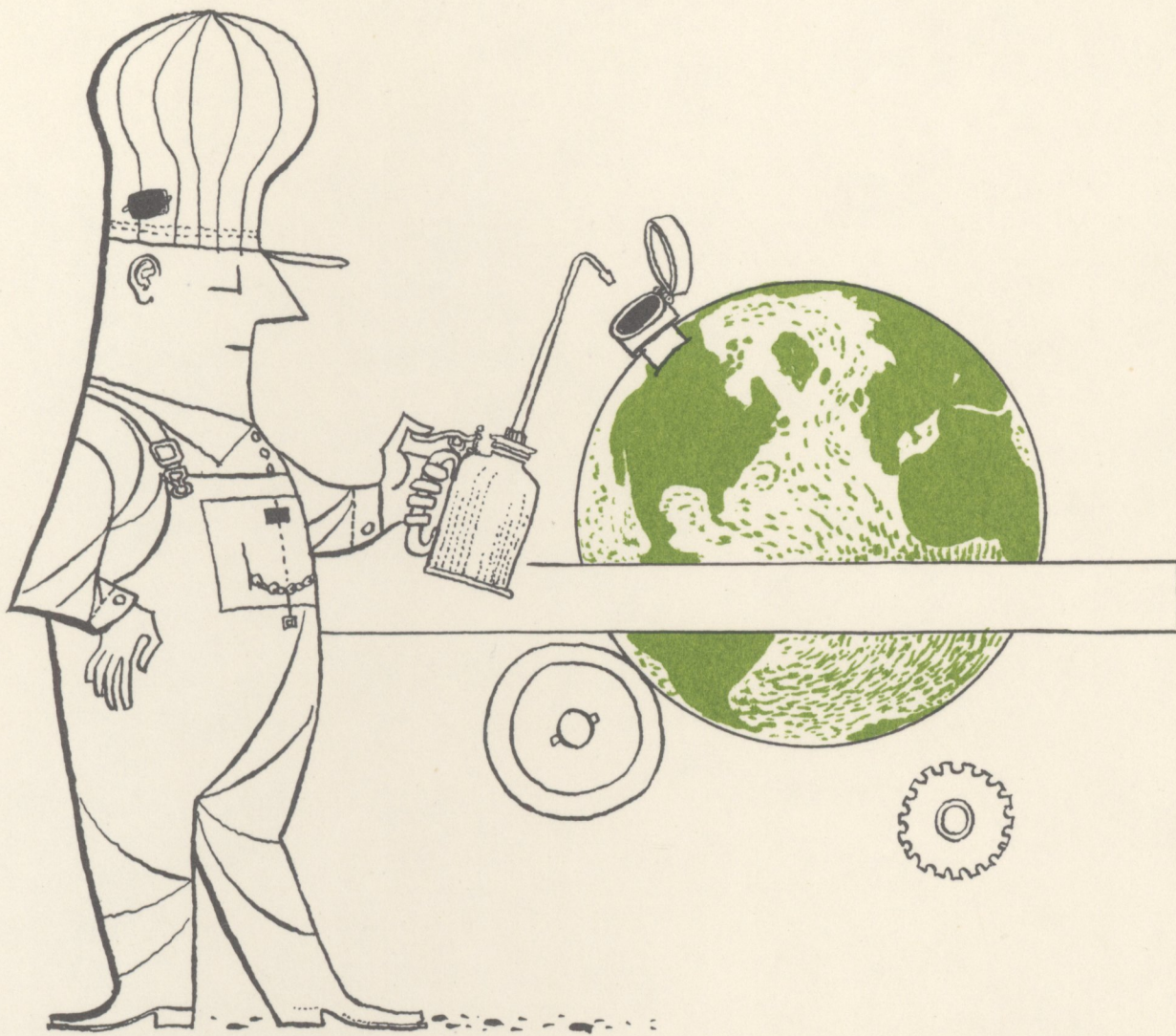
If the physician fully accepts and keeps in mind the fact that *much* of human behavior is motivated by forces beyond conscious control he will be able to set realistic and limited goals in psychotherapy. The goal of every physician is to be able to restore his patient to full health, but in the realm of emotional illness as in the rest of medicine that goal is often unattainable. In the more modest but no less vital service of relieving pain and suffering, supportive psychotherapy will always play a large part.

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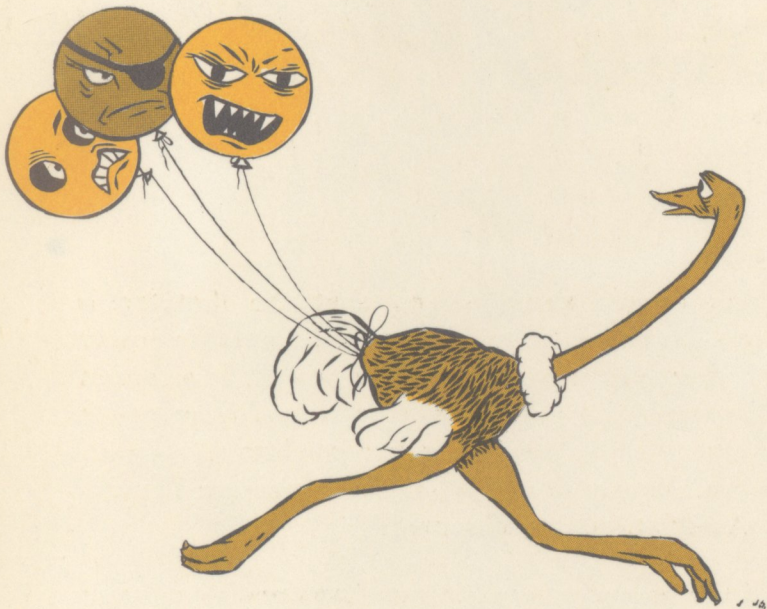
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Maintenance of Mental Health

IT HAS OFTEN BEEN NOTED that the dictator is emotionally unstable, with a morbid drive for power overshadowing the welfare of the people. If a nation is to be stable, its people must be reared from youth to assume that responsibility for freedom. Dr. Ewen Cameron, former president of the American Psychiatric Association, has observed:

"Of the many gains which we have made in recent years, one of the most important for us to bear in mind is our knowledge that hostility and anxiety are both manifold in their expressions and most virulently contagious. We must be unrelentingly alert to protect ourselves against such contagion by hostility and anxiety, forces which our long history have shown to have been far more destructive of human life than any plague."



AS KIERKEGAARD WROTE many years before Freud, "And no Grand Inquisitor has in readiness such terrible tortures as has anxiety, and no spy knows how to attack more artfully the man he suspects, choosing the instant when he is weakest, nor knows how to lay traps where he will be caught and ensnared, as anxiety knows how, and no sharp-witted judge knows how to interrogate, to examine the accused, as anxiety does, which never lets him escape, neither by diversion nor by noise, neither at work nor at play, neither by day nor by night."

SOREN KIERKEGAARD
The Concept of Dread, 1844.